# PEPFAR Ethiopia In-Country Reporting System (IRS)
# Reporting Template

## Ethiopia Community Prevention of Mother-to-Child Transmission Project (CPMTCT)

**IntraHealth International, Inc.**

## FY 2013 ANNUAL REPORT

## (OCTOBER 2012 TO SEPTEMBER 2013)

## CONTACT INFO FOR THIS REPORT:


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## LIST OF ACRONYMS

| | |
|---|---|
| ART | Antiretroviral Therapy |
| ARV | Antiretroviral |
| BCC | Behavioral Change and Communication |
| BEmONC | Basic Emergency Obstetric and Neonatal Care |
| CMSG | Community Mothers Support Group |
| CSO | Civil Society Organization |
| DCCM | Demand Creation Community Mobilization |
| EIFDDA | Ethiopian Interfaith Development and Dialogue for Action |
| EOC-DICAC | Ethiopian Orthodox Church Development and Inter Church Aid Commission |
| FANC | Focused Ante Natal Care |
| FMOH | Federal Ministry of Health |
| GOE | Government of Ethiopia |
| HAPCO | HIV/AIDS Prevention and Control Office |
| HC | Health Center |
| HEP | Health Extension Program |
| HEW | Health Extension Worker |
| HP | Health Post |
| IEC | Information, Education, and Communication |
| IFHP | Integrated Family Health Project |
| IGA | Income Generating Activities |
| IYCF | Infant & Young Child Feeding |
| IYCN | Infant & Young Child Nutrition Project |
| IOCC | International Orthodox Christian Charities |
| MNCH | Maternal, Neonatal and Child Health |
| M&E | Monitoring and Evaluation |
| MSG | Mother Support Group |
| PATH | Program for Appropriate Technology in Health |
| PEPFAR | President's Emergency Plan for AIDS Relief |
| PFSA | Pharmaceutical Fund and Supply Agency |
| PHCU | Primary Health Care Unit |
| PI | Performance Improvement |
| PMTCT | Prevention of Mother-to-Child Transmission |
| RTK | Rapid Test Kits |
| RHB | Regional Health Bureau |
| SCMS | Supply Chain Management Systems |
| TWG | Technical Working Group |
| UHEW | Urban Health Extension Worker |
| UHPDP | Urban Health Promotion and Disease Prevention |
| USAID | United States Agency for International Development |
| WHO | World Health Organization |

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## 1. Reporting period

| From: October 1, 2012 | To: September 30, 2013 |
|---|---|

## 2. Publications/reports

**Did your organization support the production of publications, reports, guidelines or assessments during the reporting period?**

**TIPS Study**

No/Not Applicable ☐
Yes ☒ If yes, please list below:

Publications/Reports/Assessments/Curriculums

| Title | Author | Date |
|---|---|---|
| CPMTCT Gender Assessment | Maryce Ramsey, IntraHealth | July, 2012 |
| Trial of Improved practices in IYCF | Ashley Aakesson Path, IntraHealth | September, 2013 |

**If Yes, Please attach an electronic copy of each document as part of your submission.**

## 3. Technical assistance

**Did your organization utilize short-term technical assistance during the reporting period?**

No/Not Applicable
Yes ☒ Please list below:

Consultants/TDYers

| Name | Arrival | Departure | Organization | Type of Technical assistance provided |
|---|---|---|---|---|
| Ashley Aakesson | Dec 2,2012 | Dec 10, 2012 | PATH | Support to the Infant and Young Child Feeding (TIPS) study |
| Lena Muldavin | May 25, 2013 | June 8, 2013 | IntraHealth International | TA in knowledge management, transition and hand-over planning, project partner management |
| Kathi Kotellos | June 17, 2013 | June 30, 2013 | IntraHealth International | Monitoring and Evaluation |
| | | | | |

**If Yes, Please attach an electronic copy of the TA report as part of your submission.**

## 4. Travel and Visits

**Did your organization support International travel during the reporting period?**

No/Not Applicable ☒
Yes ☐ Please list below:

International Travel (All international travel to conference, workshops, trainings, HQ or meetings).

| Name | Destination | Departure from Ethiopia | Arrival | Host Organization | Purpose of the travel |
|---|---|---|---|---|---|
| | | | | | |

**Have any Monitoring Visit/supervision been made to your program in during the reporting period?**

| Description of Monitoring team | Start date | End date | Sites visited | Written recommendations provided |
|---|---|---|---|---|
| Inter-Agency Task Team (IATT) members visited the Oromiya region CPMTCT project supported sites | 12/5/2013 | 13/5/2013 | Sululta HC & 1 HPs/ asoservi/ | Onsite and email feedback received; the linkage between health post and HC and program achievements are highly appreciated |
| A team from USAID & CDC visited the Oromiya region CPMTCT project supported HCs | 17/6/2013 | 17/6/2013 | Sululta HC | Written feedback received via email appreciating the project support |
| A USAID Ethiopia team visited the Amhara region | 19/6/2013 | 20/6/2013 | CPMTCT Project, Kombolcha 02 and Zobel Health centers. | Written feedback received |

| | | | | |
|---|---|---|---|---|
| A USAID Ethiopia team visited the Tigray region | 21/6/2013 | 22/6/ 2013 | CPMTCT Project, Tigray Regional Office | At regional level the guests discussed the progress of the CPMTCT project with RM and M&EO. At the end of the discussion feedback was given that the region is performing well. They expressed their concerns and advised the RO to give due focus for data quality & program sustainability. |

## 5. Activity

| Program Area | Activity ID | Activity Title |
|---|---|---|
| ☒ **01-PMTCT** | 663-A-00-09-00429-00 | Community PMTCT |
| ☐ **02-HVAB** | | |
| ☐ **03-HVOP** | | |
| ☐ **04-HMBL** | | |
| ☐ **05-HMIN** | | |
| ☐ **07-CIRC** | | |
| ☐ **08-HBHC** | | |
| ☐ **09-HTXS** | | |
| ☐ **10-HVTB** | | |
| ☐ **11-HKID** | | |
| ☐ **12-HVCT** | | |
| ☐ **13-PDTX** | | |
| ☒ **14-PDCS** | 663-A-00-09-00429-00 | Community PMTCT |
| ☐ **15-HTXD** | | |
| ☐ **16-HLAB** | | |
| ☐ **17-HVSI** | | |
| ☐ **18-OHSS** | | |

## 6. Accomplishments and successes during the reporting period

This progress report reflects activities accomplished by the CPMTCT project during FY2013 (October 1, 2012 – September 30, 2013). During this year, the focus of the project has been to continue to provide targeted support at all levels of the health system, there by contributing to

the GoE's goal of increasing MNCH/PMTCT service uptake and case follow-up. In addition, the project has invested time and effort in the past few months planning and implementing the new option B+ treatment protocol with national and regional stakeholders.

As in the previous years, the project has continued to provide technical support to FMOH, RHB and health centers, through strengthening the primary health care unit (PHCU), supportive supervision, mentoring, provision of job aids, basic and gap-filling trainings, mother-to-mother support groups (MSG), case follow up, and community mobilization. These interventions all contribute to providing quality PMTCT services and creating demand for such services.

Project staff continued to participate in national and regional PMTCT steering committee meetings, and TWGs, for example, PMTCT, Quality improvement, Continued Professional Development, New born, safe motherhood, HIV/TB/STI, and IPLS.

Proposal writing and project management skills training orientation was provided to managers and project officers from NAP+ and Adet Fana PLHIV associations in Amhara to strengthen their skills to prepare effective proposals and funding requests. In addition, orientation workshops were organized for members of HIV+ associations in the five regions to promote use of Family planning among HIV positive people, exclusive breast feeding up to the age of six months and complementary feeding thereafter as well as to address gender and male norms. The project has also provided management skill training technical support to the CSOs in the form of mentorship and supportive visits to their offices and working sites.

**Highlight on service uptake:**

The project continues to provide support to 519 health centers across the five project regions. The table below reflects key indicators for this annual reporting period.

| **Indicators** | **Results** | **Coverage (%)** |
|---|---|---|
| Number of CPMTCT supported HCs | 519 | |
| Number of new ANC clients | 407,814 | |
| Number of pregnant women with known HIV status | 351,124 | 86% of new ANC clients |
| Number of HIV+ pregnant women identified | 2,074 | |
| Number of HIV+ pregnant women on ARVs | 1,388 | 67% of HIV+ pregnant women identified |
| Number of HEIs on ARVs | 1,011 | 49% of HIV+ pregnant women identified |
| Number of male partners tested | 136,399 | 38% of pregnant women tested |

**Option B+ implementation**

The CPMTCT project staff played a key role in leading the Option B+ implementation plan and its roll-out in all regions and two town administrations; this included preparation of implementation guidelines, training packages, the official launch of Option B+, training of 9 trainers at the national level and follow-up of regional health bureaus on implementation status. In addition, the project staff participated in the development of the elimination of mother to child transmission of HIV (E-MTCT) plan, which the GoE is fully committed to.

To introduce Option B+ to RHBs, ZHDs and WrHOs, the project conducted a number of orientation meetings during which start-up and implementation of Option B+ with zonal and woreda officials and health center heads was discussed. In addition, the project's regional managers worked with their respective RHB heads and TWGs to develop and implement the regional Option B+ roll-out plans, including prioritization of sites, supply chain management and distribution of revised job aids and M&E tools. During the reporting period, the project has provided in-service training to a total of 595 health care providers in Option B+ update.

**Highlight on transition**

In anticipation of the CPMTCT project ending in September 2014 and the GOE's decision to introduce Option B+ for PMTCT, the project has revised its transition plan to include a gradual reduction of technical support to health facilities and hand-over to the respective RHB. The transition plan has been developed in close consultation with the RHBs, Zonal, Woreda office heads, and health center managers. Everyone understands, and is in agreement with, their role in increased responsibility for technical support to different levels of the health system and that the transition will be a gradual process starting in January 2014 to project close out in September 2014.

Information that the CPMTCT project will end in September 2014 has already been communicated to all the RHBs, Zonal, Woreda offices heads and health center managers.

**OBJECTIVE 1: To build the capacity of regional health bureaus, zonal and woreda health offices & community-based organizations to support and manage community- based PMTCT services**

**Support for Public Health Sector and CSO MNCH/PMTCT Policy, Materials and Management Capacity**

**National Level Support:**

- In Year 4, the project continued to support the FMOH through a full-time seconded consultant. Through this position the project has provided the following support; preparing

the FMOH PMTCT program analysis report, revising the basic generic MNCH/PMTCT training package, facilitating the national option B + Roll out Master TOT, preparing orientation package of option B + for experienced trainers national level representatives, representing the project at national, regional, continental and international E-MTCT meetings, revising M&E tool as per B + adoption, and preparing the quantification of 2006 EFY HIV commodities.

- The project also provided technical support to the FMOH by participating in the following technical working groups; safe mother hood, PMTCT, newborn and child, MSG, nutrition, FP and quality improvement. Project staff also supported the FMOH in developing; the Option B+ implementation guide, the Option B+ basic and updated training packages, the CQI training manual, a nutrition training package, E-MTCT implementation plan, revision of BEmONC training package, preparation of the national quality improvement guides and protocols, newborn intensive care unit training package revision and support for the child survival investment fund proposal writing and newborn intensive care unit assessment tools.

- The project provided technical support to the National Quality Technical Working Group and the Joint Integrated Supportive Supervision (JSS) Task Force to review training materials and develop monitoring tools and checklists. Project staff participated in the FHAPCO's bi-annual joint integrated supportive supervision visits to the regions.

- The project celebrated International Women's Day on March 8 with USAID and other implementing partners. During the event, project staff and project-supported MSGs presented two pieces of the gender based violence (GBV) quilt which was unveiled in Addis Ababa. Project staff also participated on the panel discussion highlighting the integrated activities the project has undertaken as part of its gender assessment study.

- The project has produced BCC materials (posters and brochures) on optimal IYCF practices to increase demand. The project has also duplicated and distributed counseling cards to project supported regions after translating in three local languages (Amharic, Tigrigna and Oromiya).

- The project identified CPMTCT-supported health centers encountering supply-related challenges and brought this to the PFSA's attention during a logistic meeting held in Addis Ababa. In addition, regular communications were held with national PFSA, SCMS and USAID to address any supply chain related gaps at the health center and regional levels.

**Regional Level Support:**

The project has continued to provide financial and technical support to capitalize on MNCH/PMTCT related activities at various levels in the five project supported regions. The support given to each region varies depending on the demand.

The type of support given to each region in the reporting period under consideration includes:

**In Tigray:**

- The project staff actively participated in the Regional Partners Forum, consultative committee (IntraHealth staff serves as secretary), and different TWGs such as RH/MNH, HIV/TB/STI, Systems Strengthening and pharmaceutical TWGs. As part of these efforts, the region has achieved different undertakings such as a Regional Health Festival, expansion of Option B+ PMTCT, cascading IRT, conducting two rounds of regional level ISS, and grant proposal writing for funding of HIV care and support programs.
- The project staff has actively participated in the region-wide first and second round ISS starting from the planning to implementation, during which technical, materials and financial support was given.
- The project staff have continued to participate in various meetings at regional, Woreda and PHCUs levels and shared series of experiences for advocacy.

**In Amhara:**

- The project staff actively participated in the regional TWG and addressed MNCH/PMTCT issues in the region, as a result there are promising practices regarding institutional delivery and MNCH services; Government counter parts gave emphasis on these issues at all levels.
- A zonal catchment review meeting was organized to review CPMTCT project performance; regional, zonal and woreda level officials including project supported health center heads attended the meeting. This opportunity was used to orient and sensitize the audience on option B+.
- The project staff attended woreda based planning and provided technical support.
- Woreda based bi-annual review meetings were conducted in woredas where two or more CPMTCT intervention sites exist and during each experience was shared among HEWs on the success of different DCCM strategies.

**In SNNP:**

- The project staff attended service Delivery, Quality improvement, Commodity and Child survival regional TWG meetings, where IntraHealth holds the secretary position.. Besides, the project team has attended Regional Reproductive Health (RH) Forum meetings, where the project presented its overall CPMTCT project accomplishments and shared lessons learned during this RH forum.
- The project staff attended and provided technical support to the EFY 2006 woreda-based planning workshop which was held in Yirgalem town.
- The project staff attended various quarter, semiannual and annual review meetings in most project operational zones, where IntraHealth has been recognized and given a

certificate of appreciation for its valued support for the health sector development by Gurage and K/Tembaro Zonal health departments. In addition, the project provided a vehicle for two days to support the Gedio Zone measles vaccination campaign.

- Financial and technical support was provided to Wolaita Zone for basic MNCH/PMTCT training and a total of 33 health care providers were trained from 32 health facilities.
- Technical and financial support was provided for the 2005 E.C curative and rehabilitation and multi-sectorial HIV/AIDS response core processes annual review meeting as well as the regional health extension program festival.
- The project made a financial contribution for printing 10 banners and 2000 posters on key MNCH/PMTCT messages for the regional WAD-2012 event.

**In Addis Ababa:**

- The bi-annual regional review meeting was conducted in collaboration with the regional health bureau to review PMTCT performance. People from the health promotion and disease prevention process, family health departments and health center medical directors attended the meeting.
- A one day orientation meeting on Option B+ was conducted with 22 health centers medical directors, health promotion & disease prevention case team heads, and 7 Sub city health offices, HPDP heads and family health case team heads.
- The project provided technical and vehicle support for regional level integrated supportive supervision.
- The project staff actively participated in the PMTCT task force in the accelerated PMTCT plan and UHEP monthly TWG meetings.
- Furniture, TVs and VHS were distributed to 5 new FMSG sites; Goro, Amoraw Metasebiya, Bulbula, Entoto No.2 & Nefas Silk Lafto woreda 12.

**In Oromiya:**

- The project staff participated in various meetings with RHB, PFSA and supply chain management to resolve supply related issue.
- The project staff actively participated in the regional TWG and addressed MNCH/PMTCT issues in the region, as a result a promising practice regarding institutional delivery in particular was identified and government counter parts gave emphasis on the issues at all levels.
- The project organized a zonal catchment review meeting in East Harerge, west Harege , Jimma, Arsi and West Arsi zones to review the CPMTCT project performance; regional, zonal and woreda level officials including project supported health center heads attended the meeting. In addition to reviewing PMTCT performance, an update on Option B+ was given.

- The project staff attended woreda based planning and provided technical support for this activity.
- Woreda based bi-annual review meetings have been conducted in woredas where two and more CPMTCT intervention sites exist and during the meeting experiences were shared among HEWs.
- Technical and vehicle support were provide during world AIDS day events and regional level integrated supportive supervision.

**Transition**

In Year 4, a plan on reduced program and technical support for the end of project hand-over was developed to:

- Ensure interventions to sustain key activities that have proven to improve the quality of MNCH/PMTCT services in health clinics and improve service utilization for HIV-positive mothers and HIV-exposed infants are in place in supported health centers;
- Highlight hand-over plans to transfer technical support provided to the health centers and communities to the responsibility of the district, zonal and regional health bureau by the end of the project in September 2014.

As the CPMTCT project plans to phase out technical assistance to project supported sites by the end of June 2013 (Quarter 3 FY2014), the project has already conducted various transition activities such as the assessment of sites for transition in order to prioritize the handover process. This information has been communicated to the health center manager, HC PMTCT focal person, district health office, Zonal Health Department head and RHB staff by the project's respective regional managers to ensure the region's readiness and to maximize the working and exchanging opportunity in the last year of the project.

Moreover, a desk review was undertaken to assess each site according to a set of criteria established by the project to ensure quality MNCH and PMTCT services and readiness for hand-over. Note that these transition criteria were established based on the FMOH minimum requirements to provide PMTCT services in HC setting and will be used in selecting jointly with the districts, zone and regional bureau on health centers ready to be handed over gradually throughout the last year of the project A detailed action plan to implement the hand-over has been developed at the different levels of the health system and is being implemented.

**Materials and Supply**

- The project distributed various MNCH/PMTCT supplies such as RTKs, infection prevention materials, laboratory reagents and medical equipment (Ambubags, stethoscopes, and Hemoglobin meters) to project supported sites obtained from SCMS and UNICEF. The primary purpose of this was to temporarily close existing logistics gaps in project-supported

facilities. The project team has supported and encouraged facility teams to appropriately forecast their logistical needs and to prepare and send the report and request (RRF) on a timely basis according to the schedule agreed with the existing PFSA hubs.

- The project's regional staff provided technical support to health care providers and health center directors to secure MNCH/PMTCT related pharmaceuticals and other needed medical supplies. This was done in a sustainable manner and in harmony with their health care financing scheme by supporting them on the day-to-day use of the Integrated Pharmaceuticals and Logistic System (IPLS).

- The project printed and distributed job aids and IEC materials (FANC posters, Birth Preparedness Card (BPC) cards, wall charts, danger sign posters, referral cards, partners' invitation cards, and appointment cards) to health facilities in all regions.

**Table 1: Performance for Key Indicators (Objective 1)** ¥

| PMP Ref. No. | Performance indicator | | Q1 | Q2 | Q3 | Q4 | Total to date (FY2013) | Annual Target & (% achieved to date) |
|---|---|---|---|---|---|---|---|---|
| 1.1 – 1 | # of CBOs provided with technical assistance for CPMTCT program management | | 14 | 14 | 14 | 14 | 14 | 14 (100%) |
| 1.1 – 2 | # of RHBs & woredas provided with TA for CPMTCT mgt. | RHB | 5 | 5 | 5 | 5 | 5 | 5 (100%) |
| | | Woredas | 244 | 244 | 244 | 244 | 244 | 244 (100%) |
| 1.1 – 3 | # of RHBs with active sustainability and transition plans | | 0 | 0 | 0 | 5 | 5 | 5 (100%) |
| 1.2 – 1 (H2.3.D) | # of health providers/ supervisors who successfully completed basic or refresher training in integrated MNCH/PMTCT | | 116 | 78 | 460 | 571 | 1,225¥ | 593 (207%) |
| 1.2 – 2 (H2.3.D) | # of midwives who received training on BEmONC | | 20 | 0 | 0 | 0 | 20 | 20 (100%) |
| 1.2 – 3 (H2.3.D) | # of lab technicians trained in CD4/DBS | | 0 | 26 | 0 | 77 | 103 | 92 (112%) |
| 1.3 – 1 | # of HCs included in the Pharmaceutical Fund Supply Agency (PFSA) procurement and distribution list | | 519 | 519 | 519 | 519 | 519 | 519 (100%) |

| | | | | |
|---|---|---|---|---|
| 1.4 – 1 | # of national MNCH/PMTCT guidelines/tools training materials developed or revised with project support | Reported annually: ___ | 3 | 1(300%) |
| 1.4 – 2 | # of MNCH/PMTCT policies or practices that are consistent with CPMTCT advocacy | Reported annually: ___ | | 1 |

¥ This includes Basic MNCH/PMTCT (307), Option B+ update (570), IYCF (168) training for health care providers in CPMTCT supported health centers, and also BC/CM for MNCH/PMTCT for UHEPs (80). Moreover, 25 of those who took Basic MNCH/PMTCT (gap filling) have also been trained on Option B+ update in SNNP region.

**OBJECTIVE 2: Increase access to MNCH/PMTCT services by providing facility and community services and improving bi-directional linkage/ referrals between PMTCT/MNCH services at the facility and community level.**

**MNCH/PMTCT RESULTS**

The project continues to support 519 HCs, which has a catchment population of 13,831,062, to provide integrated MNCH/PMTCT services to pregnant women, lactating mothers, male partners and their infants. The following were major achievements in service uptake by project supported health centers during the reporting period:

- **Focused antenatal care:** The project has reached 99% of its annual new ANC target, that is, 407,814 pregnant women received focused antenatal care services in project supported health centers and or health post attached to these health centers.
- **Pregnant women with known status:** 351,124 women were tested for HIV at project supported health centers, 76% (N=266,231) during outreach to health posts, 18% (N=61,586) by HEWs at health posts through task shifting 5.9% (N=22,627, and the remaining 0.2% (N=680) by UHEPs. The percentage shows the project's continued progress in contributing to health center service statistics compared to other service outlets. The regional distribution is as follows: Addis Ababa accounts for 5% (N=19,015), Amhara 24% (N=84,895), Oromiya 28% (N=98135), SNNP 21% (N=72,240) and Tigray 22% (N=76,839).
- **HIV+ pregnant women identified:** of the 351,124 pregnant women who know their status, 0.59 %( N=2,074) pregnant women were identified as HIV-positive. Of these, 61% (N=1259) were newly identified and 39% (N=815) were HIV-positive at entry. The HIV positivity rate varied among regions, as high as 2.7% in Addis Ababa and as low as 0.30% in SNNP and Oromia. Amhara was 0.9% and Tigray, 0.4% . Because of the very low declining trend and scattered distribution of the HIV+ rate, the accomplishment compared to the annual target is 66% in most of the areas. The annual target was set based on a rate of 0.80%.

- **Clinical Care &integration of services:** All HIV+ pregnant women identified were assessed for ART eligibility either through clinical staging or CD4 count, screened for TB, and counseled for family planning.
- **Antiretroviral Provision: 6**7% (N=1,388) of HIV-positive pregnant women identified received ARV prophylaxis at project supported health centers to reduce risk of mother-to-child-transmission . Of the 1,388 women, , 44% (N=605) were on HAART( Newly initiated on life-long ART, and Already on treatment), and 56% (N=783) received maternal AZT to reduce the risk of MTCT. When tracking women who have been identified in CPMTCT supported sites, but received ARV prophylaxis at non-CPMTCT supported sites, 19% (N= 409) have obtained prevention and treatment services. Looking at the cumulative figures, 87% (N=1,797) of HIV-positive pregnant women identified received ARV either in project supported HCs or elsewhere. The project's annual target for ARV coverage was 80% of HIV-positive pregnant women identified.
- **Skilled deliveries:** 83,715 deliveries were attended by skilled birth attendants at project supported health centers, which marks 118% of the annual target. In addition, among those identified positive, 47% (N=997) delivered with the assistance of a skilled birth attendant. The intervention from MSG activities contributes to this later result.
- **Partner testing:** 99% of annual target ( N=136,399) male partners of pregnant women (38% of pregnant women with known HIV status) were counseled and tested in this reporting period.

  **HEI care:** 1,011 babies born to HIV+ mothers received ARV prophylaxis, and 805 HEIs received CTX. Moreover, 599 HEIs received an HIV test within 12 months of birth where77% (N=459) were tested virologically in the first two months and 23% (N=140) were tested between 9 and 12 months either virologically and/or serology testing.

**Comparative Analysis [FY2011, FY2012 and FY2013 MNCH/PMTCT Service Data ]**

Over the life of the project, the number of CPMTCT supported HCs has gradually increased from 48 in FY2010 to 207 in FY2011 and 519 in FY2012 and FY2013. In order to measure progress over the past three years, 126 health centers, which were fully operational and had complete data for FY2011, FY2012 and FY2013 were selected for this comparative analysis. These health centers cover all five regions where the project is operating: Addis Ababa (2), Amhara (28), Oromiya (32), SNNP (25) and Tigray (39).

The changes in performances at these project supported health centers were analyzed using key MNCH/PMTCT performance indicators namely; ANC coverage, L&D coverage, ARV uptake for HIV-positive pregnant women, HEIs CTX uptake, percentage of HEIs and male partners tested.

As depicted in figure 1 below, ANC coverage increased from 47% (N=57,157) in FY2011 to 56% (N= 69,591) in FY2012 and 64% (N=77,310) in FY2013. Institutional delivery increased from 9% (N= 10,472) in FY2011 to 13% (N= 16,121) in FY2012 and 22% (N=26,526) in FY2013.To increase demand for institutional delivery the project equipped health centers with newborn corner supplies, provided BEmONC training and mentoring health care providers working in L&D unit to manage obstructed labor/other complications, and also distributed mamma kits to 393 HCs as incentive for pregnant women to deliver in a health facility.

ARV uptake by HIV-positive pregnant women increased from 47% (N=326) in FY2011 to 77% in FY2012 (N=601) and FY2013 (N=722). Uptake of HEIs CTX reached 52% (N=x377) in FY2013 from 31% (N=210) in FY2011 and 45% (N=349) in FY2012. Similarly, the percentage of HEI tested for HIV increased from 10% (N= 102) in FY2011 to 20% (N= 208) in FY2012 and 27% (N=194) in FY2013. These figures show a significant improvement across key MNCH/PMTCT indicators that reflect improvement in quality of services over time.

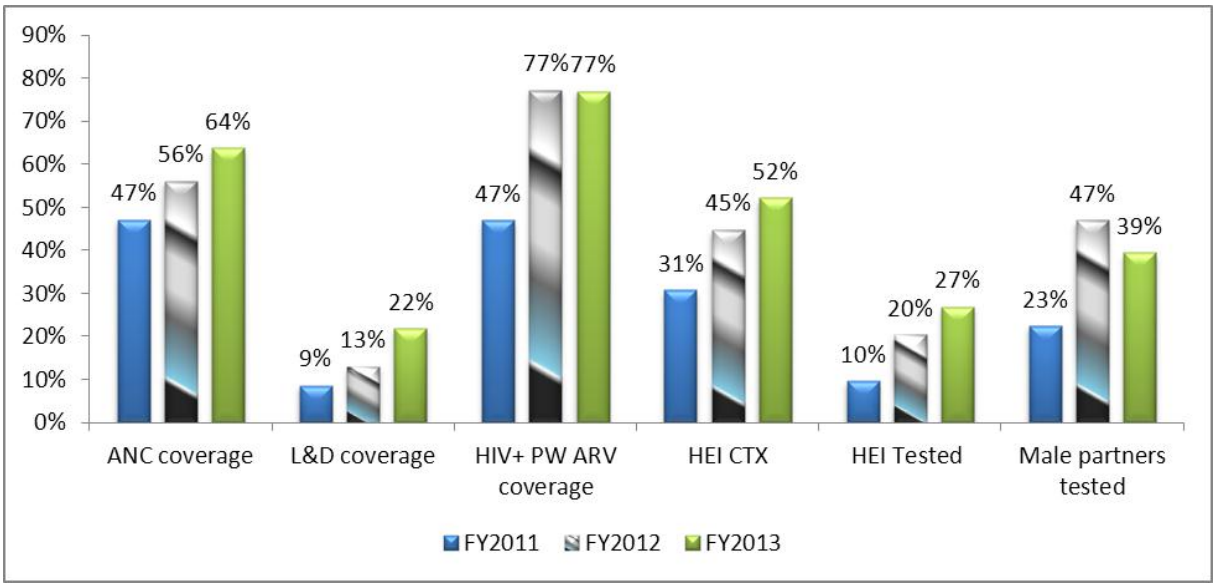

Figure 1: Performance of key MNCH/PMTCT Indicators [FY2011, FY2012, and FY2013 (N=126)]

**Follow up of mother-baby pairs**

The following two figures below, figure 2 and figure 3, show the number of HIV-positive women and HEIs traced by project support in the reporting period.

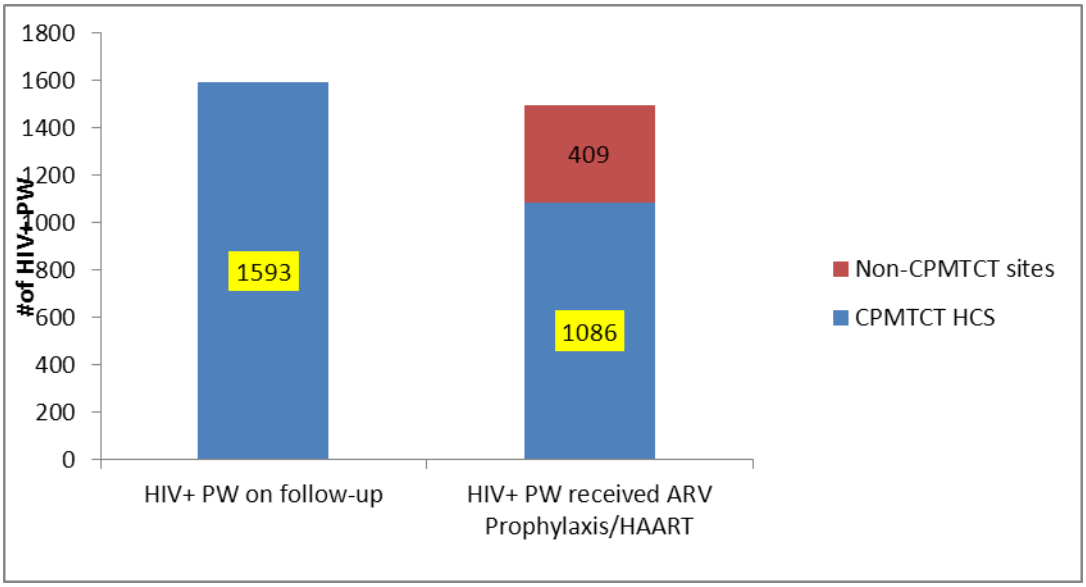


Figure 2. ARV/HAART uptake of HIV-positive women tracked during follow-up

As shown in figure 2 above, of the 1,593 HIV-positive pregnant women on follow-up during the reporting period, 94% (N=1,495) received ARV prophylaxis for PMTCT; 73% (N=1,086) obtained this service at CPMTCT supported HCs and the remaining 27% (N=409) in non-CPMTCT supported health facilities (Health centers and Hospitals).

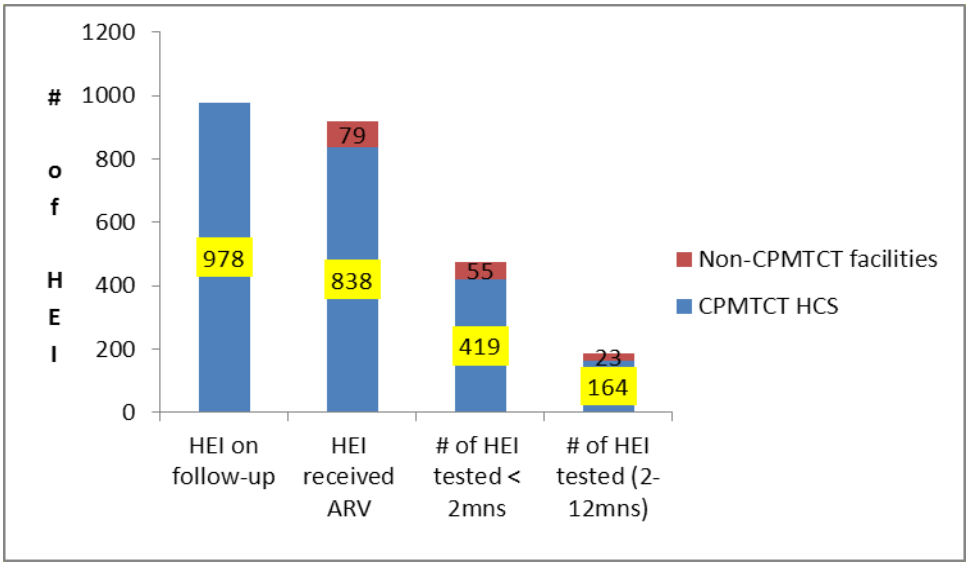


Figure 3. ARV uptake and HIV testing of HEIs traced in follow-up

As depicted in figure 3 above, out of the 978 infants born to HIV-positive mothers under follow-up by project support, 94% (N=917) received ARV prophylaxis, 48% (N=474) were tested for HIV

within two months and 19% (N=187) were tested either virologically between 2 and 12 months, or by serology between 9 and 12 months at CPMTCT supported or non-CPMTCT supported health facilities.

**Table 2: Performance for Key MNCH/PMTCT indicators (Objective 2)**

| PMP Ref. No. | Performance indicator | Q1 | Q2 | Q3 | Q4 | Total to date (FY2013) | Annual Target & (% achieved to date) |
|---|---|---|---|---|---|---|---|
| 2.1 – 1 (P1.1.D) | # of pregnant women with known HIV status (includes women who were tested for HIV and received their results) | 84,332 | 105,222 | 82,804 | 78,766 | 351,124 | 395,280 (90%) |
| 2.1 – 2 (P1.1.D) | # of HIV+ pregnant women identified in the reporting period | 513 | 551 | 527 | 483 | 2,074 | 3,205 (66%) |
| 2.1 – 3 (P1.2.D) | # of HIV+ pregnant women who received antiretroviral to reduce risk of mother-to-child-transmission at CPMTCT supported sites | 332 | 349 | 309 | 398 | 1,388 | 2,564 (55%) |
| 2.1 – 4 | # of newborns born to HIV+ mothers who received ARV prophylaxis at CPMTCT supported sites. | 255 | 254 | 242 | 260 | 1,011 | 2,083 (49%) |
| 2.1 – 5 C4.2.D) | # of HIV exposed infants who started Cotrimoxizole (CTX) prophylaxis | 184 | 176 | 178 | 267 | 805 | 1,602 (51%) |
| 2.1 – 6 (C4.1.D) | # of infants born to HIV+ mothers who received an HIV test within 12 months of birth | 186 | 142 | 137 | 134 | 599 | 1,602 (48%) |
| 2.1 – 7 | # of new ANC clients | 99,968 | 122,523 | 98,265 | 87,328 | 407,814 | 416,086 (99%) |

| PMP Ref. No. | Performance indicator | | Q1 | Q2 | Q3 | Q4 | Total to date (FY2013) | Annual Target & (% achieved to date) |
|---|---|---|---|---|---|---|---|---|
| 2.1 - 8 | # of deliveries by skilled birth attendant | | 16,022 | 20,485 | 24,544 | 23492 | 84,543 | 70,735 (118%) |
| 2.1 – 9 | # of deliveries for HIV+ women by skilled birth attendant | | 239 | 255 | 237 | 258 | 989 | 2,083 (48%) |
| 2.1 – 10 (P1.4.D) | # of HIV+ pregnant women assessed for ART eligibility through either clinical staging (using WHO clinical staging criteria) or CD4 testing | | 513 | 551 | 527 | 483 | 2,074 | 3,205 (66%) |
| 2.1 – 11 (P1.5.D) | # HIV+ pregnant women newly enrolled in care and support services | | 604 | 636 | 590 | 550 | 2,380 | 4,205 (56%) |
| 2.1 – 12 (P1.6.D) | % of infants by feeding type | # Exclusive breast feeding | 100% | 100% | 100% | 100% | 100% | 90% (110%) |
| | | # Exclusive formula feeding | 0% | 0% | 0% | 0% | 0% | 10% (0%) |
| | | # Mixed feeding | 0% | 0% | 0% | 0% | 0% | 0% |
| 2.1 – 13 | # of HIV+ mothers who were counseled on family planning | | 513 | 551 | 527 | 483 | 2,074 | 3,205 (66%) |
| 2.1 – 14 (C 2.5.D) | # of HIV+ pregnant women who were screened for TB | | 513 | 551 | 527 | 483 | 2,074 | 3,205 (66%) |
| 2.1- 15 (P11.1.D) | # of male partners of pregnant women who were tested for HIV and received results | | 29,065 | 40,180 | 33,478 | 33,676 | 136,399 | 138,699 (99%) |

| PMP Ref. No. | Performance indicator | Q1 | Q2 | Q3 | Q4 | Total to date (FY2013) | Annual Target & (% achieved to date) |
|---|---|---|---|---|---|---|---|
| 2.1- 16 (C 2.2.D) | # of HIV+ pregnant women started receiving Cotrimoxazole (CTX) prophylaxis | 65 | 88 | 109 | 77 | 339 | 641 (53%) |
| 2.2 – 1 (P1.3.D) | # of health facilities providing ANC services that provide both HIV testing and ARVs for PMTCT on site | 519 | 519 | 519 | 519 | 519 | 519 (100%) |
| 2.3 – 2 | # of MSG site coordinators who received MSG training | 0 | 5 | 33 | 105 | 143 | 80 (179%) |
| 2.3 – 3 | # of MSGs supported | 101 | 102 | 100 | 117 | 117 | 120 (98%) |

**Mother Support Groups**

The project has been supporting a total of 117 MSG sites during the fiscal year, out of which 86 MSG sites are based in the health center and 31 are Community MSG sites. Four health center based MSG sites which were not under IntraHealth support in Tigray region were handed over to MSH/ENHAT-CS. Around 26 CMSG sites in Addis Ababa (22), Oromiya (2), and SNNP (2) were closed and mentor mothers serving at CMSG site were transferred to the nearest facility based MSG for a better adherence support and reducing lost to follow up cases at the health facility and avoid duplication of effort by having community and health facility MSGs. Also member mothers were convinced to transfer in with respective mentor mothers or to the nearest health center to continue their education.

- A total of 1,278 HIV positive pregnant women (69%) and lactating mothers (31%) were newly enrolled to the program in FY2013; 278 were enrolled in CMSG and 1,000 were enrolled in facility MSG sites.
- TOT on ART adherence support was given for six MSG officers.
- Basic MSG and ART adherence support training was given to 339 MSG key personnel; 196 mentor mothers and 143 site coordinators in all regions to establish 55 new facility based

MSGs for option B+ sites as well as gap filling training for 4 existing facilities and 1 community MSG site . Of the 55 facilities, 41 of them have already started MSGs.

- Follow up supportive supervision was conducted to all community and facility based MSG sites on a monthly basis and JSS was done once quarterly for all MSG sites.
- Almost all HEIs took OI prophylaxis and DBS were taken for infants and 98% received HIV negative test result.
- Around 441 MSG member mothers graduated from three regions: Addis Ababa (350), SNNP (10) and Oromiya (81) region. Graduation entails these mothers completing 52 educational sessions and their infants receiving confirmatory test results. Only two infants tested HIV positive after confirmatory testing.
- MSG member mothers (121) were engaged in various IGA activities in partnership with health centers, OSSA, PLWHA, HAPCO, and kebeles. Some of IGA activities at SNNP region include; gardening at Tulla and Shebench on the plot of land provided by the health centers, a cafeteria service inside Shebench health center. In addition, skills training on hair dressing and embroidery were provided to the women and three MSG member husbands received help to obtain their driver's license.
- To date a total of 790 MSG members have received food support. Especially in SNNP region where MSG members at Dilla, Arbaminch, Hossaina received t food support and some members at Hawassa have seed money of around 6,500 ETB to start IGA.
- Strong referral and linkage mechanisms were reported among MSG clients and the health facilities different units.
- For newly established MSG sites at facility level the project purchased and distributed furniture for the weekly meetings. . Also monthly stipends for mentor mothers and coffee ceremony expenses were paid for all community & facility based MSG sites.
- A retrospective study was conducted in August to assess the MSG activities and its impact on service utilization among HIV-positive women and their infants. The assessment was done jointly with USAID/E, MSH/ENHAT project. Forty four health centers within five regions were assessed: Addis Ababa (8), Amhara (18), Oromiya (5), SNNP (3) and Tigray (10). Of these MSGs, 17 were supported by MSH/ENHAT and 27 by IntraHealth/CPMTCT. Final analysis is currently ongoing.
- So far 395 infants were tested for DBS and 337 infants had received confirmatory HIV testing and 8 (2.4%) turned out HIV Sero-Positive. Most of HIV positive test results were found in infants whose mothers either they didn't attend PMTCT services appropriately, delivered at home or engaged in the MSG program late in their pregnancy.
- Several consultative meetings were held with USAID and MSH to review the MSG model in light of its sustainability. The CPMTCT project provided its previous studies on the effectiveness of MSGs and data from its current activities. A joint study with all three partners was also conducted to gather up-to-date data and the content will be used to advocate the importance of MSG in PMTCT/MNCH services. Most importantly, during the

implementation of Option B+ in PMTCT only sites, MSG members will be used to support adherence among mothers. In terms of sustainability, USAID has proposed to use its existing partner, PLHIV association networks, hence, the CPMTCT project will plan accordingly to follow this approach by building the capacity of the PLHA Associations to support MSG with the goal to transfer all its MSGs to the associations by the end of the project.

**Table 3: Performance for key MSG indicators (Objective 2)**

| **Selected MSG Indicators** | | **Q1** | **Q2** | **Q3** | **Q4** | **Total to Date (FY 2013)** | **Annual Target** | **% achieved** |
|---|---|---|---|---|---|---|---|---|
| # newly enrolled in MSG | HIV+ pregnant women | 209 | 206 | 229 | 239 | 883 | 984 | 90% |
| | HIV+ non-pregnant women | 89 | 67 | 76 | 163 | 395 | 371 | 106% |
| | **Total** | **298** | **273** | **305** | **402** | **1,278** | **1,355** | **94%** |
| # newly enrolled MSG members on pre-ART or ART | Pre-ART | 92 | 108 | 113 | 26 | 339 | 478 | 71% |
| | ART | 110 | 97 | 128 | 298 | 633 | 473 | 134% |
| # MSG members who delivered | At HC/ hospital | 150 | 140 | 145 | 150 | 585 | 738 | 79% |
| | At home | 8 | 7 | 4 | 3 | 22 | 39 | 56% |
| | **Total** | **158** | **147** | **149** | **153** | **607** | **777** | **78%** |
| # (%) MSG members who delivered and received antiretroviral (ART or ARV prophylaxis | ARV prophylaxis | 67 | 67 | 41 | 10 | 185 | 381 | 49% |
| | on ART | 90 | 78 | 108 | 131 | 407 | 388 | 105% |
| | **Total** | **157 (99%)** | **145 (99%)** | **149 (100%)** | **141 (93%)** | **592 (99%)** | **769 (99%)** | **77% (100%)** |
| # (%) infants born to MSG members who received ARV prophylaxis | | 155 (98%) | 140 (95%) | 147 (99%) | 144 (95%) | 586 (97%) | 769 (99%) | 76% (98%) |
| % MSG mothers with babies < 6 months practicing exclusive breast feeding | | 100% | 99% | 100% | 100% | 100% | 100% | 100% |
| % infants of MSG members 45 days to 2 months who started Cotrimoxazole | | 100% | 100% | 99% | 96% | 99% | 100% | 99% |
| # MSG members disclosed status to partners | | 95 | 78 | 94 | 156 | 423 | 563 | 75% |

| Selected MSG Indicators | | Q1 | Q2 | Q3 | Q4 | Total to Date (FY 2013) | Annual Target | % achieved |
|---|---|---|---|---|---|---|---|---|
| # infants born to MSG mothers who received DBS testing (within 6 months of age) | Positive | 2 | 1 | 0 | 3 | 6 | 10 | 60% |
| | Negative | 130 | 89 | 61 | 109 | 389 | 612 | 64% |
| | **Total** | **132** | **90** | **61** | **112** | **395** | **622** | **64%** |
| # infants born to MSG mothers who received confirmatory HIV testing (within 9 to 18 months) | Positive | 1 | 3 | 3 | 1 | 8 | 6 | 133% |
| | Negative | 83 | 100 | 87 | 59 | 329 | 383 | 86% |
| | **Total** | **84** | **103** | **90** | **60** | **337** | **389** | **87%** |

**Increasing access to MNCH/PMTCT services using outreach support:**

Despite the GOE's aggressive expansion of health facilities, a large number of communities continue to have difficulty accessing health care services, including MNCH/PMTCT. As a temporary solution to improve access to these services, the project has supported outreach services in selected, hard to reach project supported health center catchment areas in SNNP, Oromiya and Amhara regions. The outreach support has gradually reduced in the 4$^{th}$ quarter of this year as part of gradual reduction of technical support to the supported sites and increase responsibility to the public offices.

**Primary Health Care Unit (PHCU)**

During the reporting period, the project supported and coordinated regular primary health care unit meetings during which discussions between health centers and health posts on linkages and referrals took place. The regional project staff have been coaching health center heads and service providers on planning, organizing and facilitating effective PHCU meetings using the PHCU meeting guide developed by the CPMTCT project. The FMOH has recently developed a new guide for the day-to-day operation of PHCU activities and the project staff will provide technical support to institutionalize this new guide. A total of 1,895 PHCU sessions were conducted this year.

The project continued to provide technical and minimal financial support to a number of PHCU meetings, with gradual increase in responsibility taken by the RHB. At these PHCU meetings health center staffs discuss the performance of health posts in terms of linkages from community to facility. Trends in service uptake particularly in ANC, institutional delivery, male partner testing and postnatal follow up are reviewed.

**Health center staff capacity building**

To build knowledge and skills of all providers working in MNCH/PMTCT, the CPMTC project continued to provide ongoing assessments of the health centers' staff capacity during JSS and FSS. In service training and on site follow up supervision were provided to the staff based on the needs identified. A series of trainings, ranging from Option B+ to PMTCT gap filling training were conducted to address the high staff attrition rates. During this reporting period, the project provided in-service training to a total of 1,607 health care providers. Table X reflects the summary of all training provided in FY2013.

**Table 4: Summary of trainings provided to healthcare providers from CPMTCT supported sites in each region (October 1, 2012 – September 30, 2013)** [*]

| S/N | Region | Types of trainings | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | | Option B+ PMTCT Updated | Basic MNCH/ PMTCT | BEmONC | IYCF | CD4/DBS Sample transport | Basic MSG/ Adherence support | BC/CM for MNCH/ PMTCT | Total |
| 1 | Addis Ababa | 88 | 28 | 20 | 0 | - | 25 | 50 | 211 |
| 2 | Amhara | 170 | 106 | - | 80 | 50 | 48 | - | 454 |
| 3 | Oromiya | 30 | 25 | - | 64 | - | 28 | 30 | 177 |
| 4 | SNNP | 186 | 75[∞] | - | 63 | 30 | 18 | - | 372 |
| 5 | Tigray | 96 | 73 | - | 61 | 23 | 24 | - | 277 |
| Total | | 570 | 307 | 20 | 268 | 103 | 143 | 80 | 1,491 |

[*] In addition to the 1,491 health care providers in CPMTCT supported health centers, 294 mentor mothers and CSO volunteers were trained in BC/CM for MNCH/PMTCT (44), IYCF (54), Basic MSG and adherence support (196)

[∞] 25 of the 75 health care providers who took basic MNCH/PMTCT (gap filling training) have also been trained on Option B+ update in SNNP region.

**Emphasis on gender**

In Year 3, the CPMTC project conducted a gender assessment to identify gender biases and barriers that are affecting uptake of male partner testing and institutional delivery. The findings of this study were integrated into Year 4 activities of the project, focusing on selected themes, including: disrespect and abuse (GBV) in facility-based deliveries; discordance – particularly targeting men who may believe that "her test equals my test"; clarifying and disseminating the free delivery policy; and confidentiality – what it is and isn't for both clients and providers. A module on respectful maternity care has been developed by the CPMTCT project to be given as part of the PMTCT training for health care providers, community leaders and volunteers.

**Objective 3: To increase demand for MNCH/PMTCT services through community mobilization/demand creation**

During the year, efforts were made to capitalize on the existing DCCM strategies and to address new changes and updates in PMTCT option B+ in DCCM activities to orient community members and HEWs on. DCCM sites were also revised to prioritize option B+ potential DCCM sites.

Implementation of DCCM activities at 227 health facilities focused on increasing knowledge and awareness of pregnant women and their partners on availability and benefits of MNCH/PMTCT services, benefits of SBA, exclusive breast feeding up to the age of six months, male partner engagement and support, adherence to treatment, promoting family planning among HIV+ women and creating an enabling environment for pregnant women and their partners to seek services.

Accordingly, the following major activities were accomplished in the year:

- Community level sensitization workshops were conducted in DCCM intervention sites to orient and sensitize influential community members to identify and address barriers that hinder women from accessing MNCH services. Such workshops have provided the opportunity to identify and address specific cultural normative barriers in the social environment. Health service providers, religious leaders, kebele officials and administrators, PLHIV associations' members, community leaders and youth and women groups were among the participants at these workshops.
- Sensitization workshops were held at PHCU level to orient HEWs and Health center staff on updates in line with option B+, DCCM tools and reporting templates. These workshops, especially in sites where HEWs were not trained on community mobilization skills, have given the opportunity to introduce DCCM strategies and behavior change concepts.
- Bi-annual review and planning meetings were conducted in areas where the project supports more than two PHCU to facilitate sharing of experiences and lessons among the different PHCUs. During these meetings findings of JSS visits were presented by woreda representatives and project staff to seek solutions to identified gaps. In addition, HEWs and Health centers review DCCM achievements over six months and plan together for the

coming six months. Furthermore, updates on DCCM tools and strategies were also shared with HEWs on such forums.

- IEC materials tailored to increase knowledge and awareness of the community on MNCH/PMTCT services and to address male engagement were distributed through the Health extension workers to the community based on gaps identified during JSS and FSS. Audio and video materials were also provided to MSG mentor mothers and PLHIV associations to be used during Small Group discussions.
- DCCM sites benefited from JSS/FSS visits as part of monitoring and mentoring approach to enhance the capacity of HEWs in implementing DCCM activities to increase service uptake at priority health centers through referrals and community-facility linkage.
- Opportunities like community–facility forum and pregnant women conferences were used to get access to pregnant women and their partners to disseminate key MNCH/PMTCT messages on the benefits and availability of MNCH/PMTCT services. These forums were also used to ensure linkage and social support to the pregnant women in accessing services.
- Project has supported and facilitated PHCU meetings to strengthen community facility referrals and linkages. In addition, discussions on better ways to address issues related with service quality at Health center, mobilization and linkage and documentation of daily activities at Health posts were among the agenda items emphasized during PHCU meetings.
- Behavior change and Community Mobilization (BC/CM) skills training was provided for 44 community volunteers selected from Mekdim Ethiopia, Down of Hope & ANOPA+ in Addis Ababa. These trainees were attached to health centers in their catchment and their activities were coordinated with UHEPs and MSG mentors to ensure coordination and collaboration.
- Monthly review and planning meetings were held with volunteers from Tesfa Goh, Mekdim, ANOPA+ and Negem Lela Ken New (NLK) to discuss monthly performance, challenges faced and way forward. It is also to let volunteers from the different CSOs share experiences and lessons in the field.
- To strengthen the role of UHEPs in DCCM and linkage of HIV-positive pregnant women to treatment and services, the project has provided refresher training for UHEPs in five towns of the Oromiya region. The UHEPs were engaged in house to house HTC of pregnant women and linkage for routine MNCH/PMTCT services.
- The project has also provided technical and material support to regional health bureaus during the 2012 World AIDS Day event to promote PMTCT messages and to support discussion forums on MNCH/PMTCT.
- Three Project staffs were trained on Male Engagement concepts organized by E2A project. Selected concepts from this training were introduced into existing DCCM orientation and sensitization workshops to promote male engagement and male support to their pregnant women.

- IOCC volunteers and focal persons conducted monthly review meetings at their respective catchments areas which allow them to discuss the timeliness and completeness of project reports, best practices, challenges faced and any other issues in relation to the project. To this end, community mobilization facilitators take part in the meeting at catchments areas on a quarterly basis. Due to the distance from the regional office to the implementing sites, this may not be realistic in some areas.
- During this reporting period, IOCC was able to adopt and customize job aids for volunteers of the faith based organizations. The job aids included booklets that religious volunteers can read and increase their understanding of the key messages they disseminate to the beneficiaries of the project. Six hundred fifty job aids have been printed and distributed to religious volunteers. Necessary orientations were made on the use of these job aids.
- IOCC/EOC-DICAC and IOCC/EIFDDA have held a central level review meeting in Bahir Dar and Adama, respectively. During the review meeting, a number of issues regarding the challenges and best practices observed during supportive supervision and the actual implementation of the CPMCT project were discussed. A total of 27 EOC-DICAC and EIFDDA central office program and finance staff, IOCC program coordinator and regional level social workers and coordinators attended the review meeting.
- The project completed the TIPS study and organized TIPs dissemination workshops in Amhara and Tigray regions as well as National level. All stakeholders have attended the workshop and important feedback was collected. Findings will be used in IYCF related activities in the last year of the project.
- The project continued to provide technical knowledge on maternal nutrition and infant feeding and nutrition in the context of PMTCT at all levels through training on up-to-date IYCF and HIV services focusing on priority health centers with high prevalence. In addition to these trainings, CPMTCT program officers provided ongoing site level support as part of their supportive supervision. As part of quality assurance on knowledge transfer to the health centers' staff, interviews and observations at health centers on the quality of maternal nutrition activities in ANC were conducted and recommendations used for improvement.

**Table 5: Performance for Key DCCM for MNCH/PMTCT Indicators (Objective 3)**

| PMP Ref. No. | Performance indicator | Q1 | Q2 | Q3 | Q4 | Total to date (FY2013) | Annual Target & (% achieved to date) |
|---|---|---|---|---|---|---|---|
| 3.1 – 1 | # of the targeted population reached with individual and/or small group level preventive interventions that are based on evidence and/or meet the minimum standards required | 59,570 | 63,384 | 50,305 | 76,827 | 250,085 | 256,800 (97%) |
| 3.1 – 2 | # of referrals from community-based and health post workers acted on by clients attending ANC/PMTCT services | 17,292 | 17,213 | 8,918 | 6,279 | 49,702 | 46,224 (106%) |
| 3.1 – 3 | # of IEC/BCC materials distributed at community level | 4,216 | 3,549 | 4,690 | 2,168 | 14,893 | 20,800 (72%) |
| 3.1 – 4 (H2.2.D) | # of community volunteers trained in PMTCT | 24 | 34 | 49 | 187 | 294 * | 220 (134%) |
| 3.2 – 1 | # of HCs holding PHCU meetings at least once quarterly | 389 | 446 | 421 | 404 | 446 | 519 (86%) |

* This includes trainings on BC/CM for MNCH/PMTCT (44) for CSO volunteers, IYCF (54) and Basic MSG/Adherence support (196) trainings for mentor mothers

**OBJECTIVE 4: Improve the quality of community and facility-based MNCH/PMTCT services**

To improve and sustain health centers' performance and quality of care, the project has produced performance/quality assurance tools, training materials, provision of PQI/CQI training, monitoring of service delivery provision and ensuring the implementation of sustainability strategies. To share experiences and to create smooth partnerships with other implementing partners, the project staff actively participated at federal and regional level in joint, integrated supportive supervision visits, technical working groups, performance review meetings, professional associations and national forums and workshops that dealt with performance improvement.

During the reporting period, the project provided focused support in terms of improving performance and achieved the following key performances:

**Developed/reviewed quality assurance tools and training materials**

- To use updated tools by all project staffs, joint supportive supervision checklist; SS and mentoring guide; qualitative reporting template; annual quality of care assessment tools and training quality monitoring tools have been reviewed /developed.
- As per national guidance, continuous quality improvement training materials and internal assessment tools have been adopted to use in all project supported sites.
- The project in country together with CH staff developed woman friendly maternity care training materials and service delivery quality improvement tools.

**Facilitated trainings**

- As part of option B+ updated training, continuous quality improvement training has been given to project staff such that they can cascade these trainings to their respected project supported sites.
- As per the gender assessment recommendation, women friendly maternity care training has been provided to all program staffs to integrate in all project supported trainings so as to improve the MNCH/PMTCT performance.

**Monitored quality of service delivery provision in project supported sites**

- The project continues providing technical and financial support for quarterly joint supportive supervision visits in all project supported health facilities. Project staff also used this opportunity to advocate for FMOH focused areas, specifically maternal and child

health related issues. In addition to JSS, program officers performed follow-up supervision visits 905 (62%) and mentoring in between the JSS visits.

- As a part of FSS which includes observation, project staffs have conducted a portion of the QOC assessment in 29 HCs which ensure and monitor the quality of care status in the supported facilities.
- The project conducted the national quality of care assessment for the second time in 84 sampled health centers in the fourth quarter. Data entry is already completed and final analysis is currently ongoing. Findings will be used to improve Year 5 program activities.

**Ensured and mentored the implementation of supported health centers' performance sustainable strategies**

- One of the key elements of the sustainability strategy on service uptake and quality of care, the project staffs provided mentoring to health center managers and health care providers to apply self-assessments using their own checklists.
- The project provided technical and financial support during national and regional level joint integrated supportive supervisions (JISS). These activities present opportunities to share our experiences and gain from other partners that are working in similar programs.

**Table 6: Performance for Key Quality Improvement Indicators (Objective 4)**

| PMP Ref. No. | Performance indicator | Q1 | Q2 | Q3 | Q4 | Total to date (FY2013) | Annual Target & (% achieved to date) |
|---|---|---|---|---|---|---|---|
| 4.1 – 1 | % health facilities meeting the requisite standard of care for PMTCT | To be reported annually: __ | | | | | 80% |
| 4.1 – 2 | % health facilities with acceptable data quality | To be reported annually: __ | | | | | 85% |
| 4.3 – 1 | # of service sites receiving joint supportive supervision visits (JSS) regularly | 493 | 498 | 436 | 342 | 519 | 519 (100%) |
| 4.4 – 1 | # of follow-up visits for mentoring PMTCT service providers | 258 | 248 | 194 | 205 | 905 | 1,457 (62%) |

## 7. Challenges and Constraints and plans to overcome them during the reporting period

Challenges and Constraints seen during the quarter for each program area

- Although there were marked improvements in availability of drugs, logistics and supplies, this year compared to previous years, stock-outs of test kits, drugs including ARVs, and IP materials required for the provision of MNCH/PMTCT services in supported health centers remain a challenge.

- Due to the absence of CD4/DBS sample transportation system in most project supported health centers, the project continued to lose potential clients.

- Shortages of basic medicines and diagnostics such as emergency drugs, laboratory reagents, and medical and laboratory equipment affect the provision of standard and comprehensive MNCH/PMTCT care.

- Despite ongoing discussions at various levels to resolve the challenges related to the high turnover of trained staff, rapid turnover is the major challenge in the implementation of the integrated MNCH/PMTCT program in the CPMTCT project supported sites in the current reporting period. In some sites service providers have left the facilities immediately after they received the gap filling basic MNCH/PMTCT training by the CPMTCT project.

- Though there were repeated discussion with RHBs and the respective sub city health offices, five project supported health centers in Addis Ababa region were unable to provide obstetric services due to lack of water and other infrastructure problems.

- Variation in the reporting periods of different regions caused some challenges for the timeliness of this report submission. In addition, the new HMIS has not been implemented in some of supported health facilities in Oromiya region, which also created a gap in capturing all indicators.

Plans to overcome challenges and constraints in each of your program areas

- Project staffs continue to meet regularly with the RHBs, PFSA, SCM and regional laboratories to update them on the list of PMTCT sites to address the gap in supplies and to ensure a common understanding of the policy pertaining to non-ART PMTCT sites.

- Follow up of the implementation of the new Early Infant Diagnosis guidelines to resolve the challenges in DBS/CD4 sample transport and turnaround time. Advocate for the proper utilization of health care financing for procurement of essential drugs and supplies to strengthen MNCH/PMTCT services through JSS and various review meetings.

- In an attempt to address the high turnover of trained health workers, project staff, will continue to work closely with woreda health officers and HC managers to ensure that at

least 4 staff members per health center are trained in MNCH/PMTCT. The project will also try to recruit mentor mothers as much as possible since these are voluntary positions.

- The project staff in Addis Ababa region has facilitated discussions with Addis Ababa RHB to resolve problems that hinder obstetric service provision.

- In order to comply with the report submission date, all project staffs at regional level will be involved in data collection. Furthermore, the Country Office will provide support if regions demand additional support.

## 8. Data Quality issues during the reporting period

Specific concerns you have with the quality of the data for program areas reported in this report

- Some facilities lack consistent reporting due dates despite clear direction from RHB. As a result, facility providers compile service delivery reports at different dates for different months, that is, the number of days in the reporting period is different for different months. This type of practice hinders knowing the performance trends of the indicators over time. In some cases, the new HMIS system is not even introduced.

- All indicators required by the project cannot be collected from the HMIS at facility level (i.e. TB screening, partner testing in labor and delivery), which affects reporting quality. Use of old and new HMIS registers, shortage of HMIS registers and forms, some missing data from the facilities due to difference in timeline of PEPFAR reporting and the GOE HMIS reporting calendar, and lack of trained staff at HC continue to adversely affect the accuracy, consistency and completeness of data reported from HCs.

What you are doing on a routine basis to ensure that your data is high quality for each program area

Project staff continue to have discussions on data quality issues with RHB/ZHD and WrHO and put in place innovative ways to capture the required indicators such as tally sheets and using the remark column of the HMIS register, and distributing pre-ART registers to health centers. CPMTCT project regional M&E officers and SDOs perform regular data quality checks during joint supportive supervision and data collection. The CO staff also provide quarterly data quality checks during supervision.

How you planned to address those concerns / improve the quality of your data for each program area

For those indicators not captured by HMIS, health care providers have been advised to record this data on the remarks column of the registers and to use a tally sheet to collect the data regularly.

## 9. Major Activities planned in the next quarter [October to December 2013]

- Conduct Year 4 CPMTCT project performance review and organize annual staff retreat.
- Develop and submit CPMTCT Yr 5 work plan and budget.
- Conduct JSS visits in all HCs supported by the project and FSS visits in all more intensively supervised/mentored HCs. Conduct SS in all MSG and DCCM sites and mentoring to BEmONC and Option B+ sties.
- Strengthen MNCH/PMTCT services at facility level by revising the project site support strategy (frequencies of JSS and FSS) based on current patient loads and hand-over plan
- Conduct training: basic and gap filling BEmONC training, gap filling option B+ , basic MNCH/PMTCT training, and basic MSG and ART Adherence support trainings for mentor mothers and site coordinators.
- Provide technical support to zonal catchment and PHCU meetings to resolve supply, training and demand issues and distribute mamakits to supported sites.
- Conduct MSG activities - strengthen the linkages between MSG sites for IGA activities in consultation with other partners working on IGA; Conduct coffee ceremony session at high yield catchments areas; Conduct MSG members graduation; Transit matured sites to available MSG supporter.
- Continue demand creation and community mobilization activities; Conduct monthly review meetings for volunteers at health center catchment areas; Conduct supportive supervisions to EOC-DICAC and EIFDDA intervention sites.
- Implement planned transition related activities by holding regular follow up meetings with RHB, Zonal and Woreda offices and reducing level of effort based on the proposed plan.
- Work closely with PFSA to strengthen the supply issues; Actively follow-up the materials distributed to HCs (i.e. HIV test kits, IP materials, and laboratory reagents) to ensure effective and efficient use for the intended purpose.
- Conduct dissemination workshop on QoC findings.
- Continue to participate in different TWGs and support the implementation of the accelerated PMTCT plan in supportive supervision, CQI and demand creation.
- Finalize RDQA data collection and report writing.

## 10. Environmental compliance

Describe any issues related to environmental compliance (if there are any)

The project has continued in ensuring all the activities of the CPMTCT project are implemented in accordance with the Environmental Complaisance and Mitigation Plan. Materials used during various training sessions for demonstration like gloves, syringes, RTK, ARV drugs; FP commodities, etc. have been properly collected and taken for disposal at the regional laboratory premises. Furthermore, all sharp medical tools were properly collected using sharp boxes and disposed as per the infection preventions guideline in all of the training places. In addition, in all CPMTCT supported sites, project staff constantly coach facility staff to properly collect, handle and dispose all medical hazards as per the infection prevention standard. Currently, almost all project supported sites have incinerators; placenta pits, medical equipment processing instruments, various infection prevention materials, etc. Furthermore, infection prevention practice has been an integral part of all MNCH/PMTCT related trainings.

## 11. Financial accomplishment (in USD)

| **Life of Project budget**<br><br>**(a)** | **Obligated To date**<br><br>**(b)** | **Expenditure (Accrual and actual disbursement) To date**<br>**(c)** | **Remaining balance**<br><br>**(d) = (b) – (c)** | **Remarks** |
|---|---|---|---|---|
| $31,827,000.00 | $28,949,223 | $25,791,912 | $3,157,311 | |

## 12. Issues requiring the attention of USAID Management

Identify and state issues that USAID needs to look at and address for each program area

Follow-up with the support of SCMS on supply chain management issues, particularly focusing on supply of ARV, CD4/DBS sample collection and transportation system, test kits and staff training on supply chain.

## 13. Data Sharing with Host Government:

Have you shared this report with the host government?

Yes ☐
No ☒

If yes, to which governmental office/s?

If No, why not?

After submitting the report to the mission, the report will be shared to FMOH, Urban and Agrarian Health Promotion Disease Prevention Directorate (if required).

## 14. Appendices

TIPS Study